		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028480

Facility Name: MOMENCE MEADOWS NURSING CENTER

Address: 500 SOUTH WALNUT (Number) MOMENCE (City) 60954 (Zip Code)

County: KANKAKEE

Telephone Number: (815) 472-2423 **Fax #** (815) 472-6212

IDPA ID Number: 36-3269481

Date of Initial License for Current Owners: 02/01/84

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) JACOB GRAFF
(Title) SECRETARY

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	140	Skilled (SNF)	140	51,100	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	140	TOTALS	140	51,100	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	40,525	3,087	3,606	47,218	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	40,525	3,087	3,606	47,218	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.40%

D. How many bed-hold days during this year were paid by Public Aid?
647 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/84

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/84 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 12 and days of care provided 3,241

Medicare Intermediary ADMINASTAR FEDERAL

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTI # 0028480 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	214,608	14,990	8,489	238,087		238,087	0	238,087			1
2	Food Purchase		225,597		225,597	(12,125)	213,472	(148)	213,324			2
3	Housekeeping	195,768	18,823	0	214,591		214,591	0	214,591			3
4	Laundry	102,434	15,318	0	117,752		117,752	0	117,752			4
5	Heat and Other Utilities			93,854	93,854		93,854	248	94,102			5
6	Maintenance	0	35,014	43,593	78,607		78,607	4,161	82,768			6
7	Other (specify):*			10,549	10,549		10,549	0	10,549			7
8	**TOTAL General Services**	512,810	309,742	156,485	979,037	(12,125)	966,912	4,261	971,173			8
	B. Health Care and Programs											
9	Medical Director	0		14,000	14,000		14,000	0	14,000			9
10	Nursing and Medical Records	1,685,995	73,565	78,488	1,838,048		1,838,048	0	1,838,048			10
10a	Therapy	112,490		8,350	120,840		120,840	0	120,840			10a
11	Activities	105,807	34,026	50	139,883		139,883	0	139,883			11
12	Social Services	54,052		5,475	59,527		59,527	0	59,527			12
13	Nurse Aide Training			0	0		0	0	0			13
14	Program Transportation			158	158		158	0	158			14
15	Other (specify):*				0		0	0	0			15
16	**TOTAL Health Care and Programs**	1,958,344	107,591	106,521	2,172,456	0	2,172,456	0	2,172,456			16
	C. General Administration											
17	Administrative	107,705		332,002	439,707		439,707	(274,764)	164,943			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			246,755	246,755		246,755	(19,135)	227,620			19
20	Dues, Fees, Subscriptions & Promotions			82,245	82,245		82,245	(42,924)	39,321			20
21	Clerical & General Office Expenses	6,290	17,407	360,576	384,273		384,273	(228,353)	155,920			21
22	Employee Benefits & Payroll Taxes			359,747	359,747	12,125	371,872	0	371,872			22
23	Inservice Training & Education			5,435	5,435		5,435	50	5,485			23
24	Travel and Seminar			37,092	37,092		37,092	(29,674)	7,418			24
25	Other Admin. Staff Transportation			18,422	18,422		18,422	0	18,422			25
26	Insurance-Prop.Liab.Malpractice			85,264	85,264		85,264	0	85,264			26
27	Other (specify):*			0	0		0	20,374	20,374			27
28	**TOTAL General Administration**	113,995	17,407	1,527,538	1,658,940	12,125	1,671,065	(574,426)	1,096,639			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,585,149	434,740	1,790,544	4,810,433	0	4,810,433	(570,165)	4,240,268			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER #0028480 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			127,356	127,356		127,356	50,472	177,828			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			631,216	631,216		631,216	0	631,216			32
33	Real Estate Taxes			53,147	53,147		53,147	0	53,147			33
34	Rent-Facility & Grounds				0		0	0	0			34
35	Rent-Equipment & Vehicles			44,861	44,861		44,861	7,533	52,394			35
36	Other (specify):* MTG AMORT			98,724	98,724		98,724	0	98,724			36
37	TOTAL Ownership			955,304	955,304	0	955,304	58,005	1,013,309			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers		108,916	95,769	204,685		204,685	0	204,685			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			76,650	76,650		76,650	0	76,650			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	108,916	172,419	281,335	0	281,335	0	281,335			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,585,149	543,656	2,918,267	6,047,072	0	6,047,072	(512,160)	5,534,912			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	50,472	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(148)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(29,674)	24		16
17	Non-Care Related Fees	0	20		17
18	Fines and Penalties	(3,205)	21		18
19	Entertainment	0	20		19
20	Contributions	(140)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers	(20,071)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(35,942)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(7,371)	20		28
29	Other-Attach Schedule SEE PAGE 5A	11,740			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (34,339)		$ 0	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(477,821)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (477,821)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (512,160)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

MOMENCE MEADOWS NURSING CENTER

ID# 0028480

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 4161	6	1
2	BANK CHARGES	(15,171)	21	2
3	transferred costs from related nursing home(skokie 1)	22,750	17	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	11,740		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(148)	0	0	0	0	0	0	0	0	0	0	(148)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	248	0	0	0	0	0	0	0	0	0	248	5
6	Maintenance	4,161	0	0	0	0	0	0	0	0	0	0	4,161	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	4,013	248	0	0	0	0	0	0	0	0	0	4,261	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	22,750	(297,514)	0	0	0	0	0	0	0	0	0	(274,764)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(20,071)	936	0	0	0	0	0	0	0	0	0	(19,135)	19
20	Fees, Subscriptions & Promotions	(43,453)	529	0	0	0	0	0	0	0	0	0	(42,924)	20
21	Clerical & General Office Expenses	(18,376)	(209,977)	0	0	0	0	0	0	0	0	0	(228,353)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	50	0	0	0	0	0	0	0	0	0	50	23
24	Travel and Seminar	(29,674)	0	0	0	0	0	0	0	0	0	0	(29,674)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	20,374	0	0	0	0	0	0	0	0	0	20,374	27
28	**TOTAL General Administration**	(88,824)	(485,602)	0	0	0	0	0	0	0	0	0	(574,426)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(84,811)	(485,354)	0	0	0	0	0	0	0	0	0	(570,165)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	50,472	0	0	0	0	0	0	0	0	0	0	50,472	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	7,533	0	0	0	0	0	0	0	0	0	7,533	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	50,472	7,533	0	0	0	0	0	0	0	0	0	58,005	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(34,339)	(477,821)	0	0	0	0	0	0	0	0	0	(512,160)	45

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
ATTACHED SCHEDULE		SKOKIE MEADOWS 1	SKOKIE	PREMIER MGMNT	SKOKIE	MANAGEMENT
		SKOKIE MEADOWS 2	SKOKIE			BOOKKEEPING
		SHELDON MEADOWS	SHELDON			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEE	$ 332,002			$	$ (332,002)	1
2	V	21	OUTSIDE CLERICAL	320,500				(320,500)	2
3	V	5			PREMIER MANAGEMENT	100.00%	248	248	3
4	V	17			PREMIER MANAGEMENT	100.00%	34,488	34,488	4
5	V	19			PREMIER MANAGEMENT	100.00%	936	936	5
6	V	20			PREMIER MANAGEMENT	100.00%	529	529	6
7	V	21			PREMIER MANAGEMENT	100.00%	56,463	56,463	7
8	V	27			PREMIER MANAGEMENT	100.00%	20,374	20,374	8
9	V	23			PREMIER MANAGEMENT	100.00%	50	50	9
10	V	35			PREMIER MANAGEMENT	100.00%	7,533	7,533	10
11	V	21			PREMIER MANAGEMENT	100.00%	54,060	54,060	11
12	V								12
13	V								13
14	Total			$ 652,502			$ 174,681	$ * (477,821)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number MOMENCE MEADOWS NURSING CENT # 0028480 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JACOB GRAFF	PRESIDENT	Administrative	14.30	63,751	7	14.00	Mnmnt fee	$ 34,488	17-7	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 34,488		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREMIER MANAGEMENT
Street Address: 9933 N. LAWLER
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: ((847)679-7733
Fax Number: ((847)679-7734

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PER RESIDENT DAY	10,000	5	$ 900	$	2,759	$ 248	1
2	17	OFFICER SALARY	PER RESIDENT DAY	10,000	5	125,000	125,000	2,759	34,488	2
3	19	DATA PROCESSING	PER RESIDENT DAY	10,000	5	3,394		2,759	936	3
4	20	DUES & SUBSCRIPTIONS	PER RESIDENT DAY	10,000	5	1,919		2,759	529	4
5	21	CLERICAL	PER RESIDENT DAY	10,000	5	204,649	134,850	2,759	56,463	5
6	27	PAYROLL TAXES	PER RESIDENT DAY	10,000	5	73,847		2,759	20,374	6
7	23	SEMINARS	PER RESIDENT DAY	10,000	5	183		2,759	50	7
8	35	OFFICE RENT	PER RESIDENT DAY	10,000	5	27,304		2,759	7,533	8
9	21	CLERICAL	PER RESIDENT DAY	10,000	5	153,972	153,972	3,511	54,060	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 591,168	$ 413,822		$ 174,681	25

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTE # 0028480 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LTC PROPERTIES		X	MORTGAGE	$42,919.00	01/22/93	$ 4,100,000	$ 0			$ 361,922	1
2	CAMBRIDGE REALTY		X	HUD MORTGAGE	$42,564.00	08/01	6,526,000	6,512,025	07/36		204,423	2
3												3
4												4
5												5
	Working Capital											
6	COLE TAYLOR		X	WORKING CAPITAL	INTEREST			780,142		PRIME+	50,974	6
7	SUCCESS NATIONAL BANK		X	WORKING CAPITAL	$5,595.00		180,000	120,000		PRIME+	13,897	7
8												8
9	TOTAL Facility Related				$91,078.00		$ 10,806,000	$ 7,412,167			$ 631,216	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 10,806,000	$ 7,412,167			$ 631,216	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 55,005	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 54,076	2
3. Under or (over) accrual (line 2 minus line 1).		$ (929)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 54,076	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 53,147	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	58,941	8
	1997	58,840	9
	1998	55,642	10
	1999	55,005	11
	2000	54,076	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME MOMENCE MEADOWS NURSING CENTER COUNTY KANKAKEE

FACILITY IDPH LICENSE NUMBER 0028480

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	05-11-19-306-007	NURSING HOME	$ 54,075.86	$ 54,075.86
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 54,075.86	$ 54,075.86

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 17,850 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 26,183	1
2				6,000	2
3	TOTALS			$ 32,183	3

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	78		1983		$ 1,071,430	$	20	$ 53,572	$ 53,572	$ 966,527	4
5			1983		28,288		19	1,489	1,489	26,562	5
6	50		1989		1,359,883	43,171	31.5	43,171		527,029	6
7	12		1994		381,788	9,789	39	9,789		76,285	7
8											8
	Improvement Type**										
9	IMPROVEMENTS			1984	11,728		15	782	782	11,628	9
10	IMPROVEMENTS			1985	10,412	541	10	1,041	500	9,116	10
11	IMPROVEMENTS			1986	8,150	424	20	408	(16)	6,324	11
12	IMPROVEMENTS			1987	1,655	53	20	83	30	1,204	12
13	IMPROVEMENTS			1987	513	16	20	26	10	377	13
14	IMPROVEMENTS			1988	33,260	1,056	31.5	1,056		14,300	14
15	IMPROVEMENTS			1989	9,914	315	31.5	315		3,813	15
16	IMPROVEMENTS			1990	7,043	224	31.5	224		2,514	16
17	IMPROVEMENTS			1991	66,745	2,118	31.5	2,118		22,282	17
18	IMPROVEMENTS			1992	14,756	468	31.5	468		4,493	18
19	IMPROVEMENTS			1993	3,240	103	31.5	103		914	19
20	IMPROVEMENTS			1993	18,662	479	39	479		3,852	20
21	IMPROVEMENTS			1994	2,799	72	39	72		549	21
22	BOOSTER PUMP & MIXING VALVE			1995	7,865	202	39	202		1,303	22
23	TWO WATER HEATERS			1995	6,886	177	39	177		1,201	23
24	HALLWAY HEATER			1995	815	21	39	21		127	24
25	STEEL DOOR			1996	1,679	43	39	43		249	25
26	PLUMBING			1996	3,219	83	39	83		452	26
27	TILE,WALL BUMPERS,HAND RAIL & RIGIWALL			1996	26,342	675	39	675		3,403	27
28	CORNERGUARDS,WALL BUMPER & HANDRAIL			1997	1,584	41	39	41		199	28
29	REWIRE NURSE STATION ROOFTOP UNIT			1997	4,298	110	39	110		537	29
30	ALZHEIMERS REMODELING			1997	11,002	282	39	282		1,375	30
31	ROOF TOP UNITS			1997	7,875	202	39	202		985	31
32	CONCRETE WORK			1997	1,650	42	39	42		194	32
33	HVAC			1997	3,912	100	39	100		438	33
34	EMERGENCY LIGHTING			1997	4,125	106	39	106		464	34
35	ROOF TOP HEATING/AC UNIT			1997	6,500	167	39	167		740	35
36	ROOF TOP UNITS,CORNER GUARDS,CORRIDER CALL LIFES			1998	12,400	318	39	318		1,231	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	NEW DRIVEWAY,FIRE DRAWER,BACKFLOW PREVENTOR	1998	$ 16,667	$ 427	39	$ 427	$	$ 1,547	37
38	ROOF TOP UNITS	1998	13,126	337	39	337		1,136	38
39	ROOF INSULATION,RUBBER COVE BOX,ROOF TOP UNIT	1998	23,942	614	39	614		1,919	39
40	ROOF TOP A/C UNIT	1999	6,673	171	39	171		435	40
41	DOORS	1999	2,892	74	39	74		188	41
42	COUNTERTOPS WITH SINKS & FAUCETS	1999	3,460	89	39	89		225	42
43	LIFT STATION FOR DRAIN PLUMBING	1999	2,971	76	39	76		193	43
44	DOORS	1999	1,635	42	39	42		107	44
45	FIRE ALARM PANEL	1999	1,585	41	39	41		103	45
46	EXHAUST FAN	1999	870	22	39	22		56	46
47	ALARM	1999	2,123	54	39	54		137	47
48	EXHAUST FAN	1999	900	23	39	23		59	48
49	COMPRESSOR	1999	2,942	76	39	76		192	49
50	PANNING CAMERA	1999	1,940	50	39	50		126	50
51	BOOSTER FOR WATER HEATER	1999	3,114	80	39	80		203	51
52	CUSTOM NURSING DESK	2000	6,567	239	27.5	239		358	52
53	WATER SOFTENER	2000	5,850	213	27.5	213		319	53
54	TREES	2000	10,974	732	15	732		1,098	54
55	BASEBOARD HEATERS	2000	4,773	169	27.5	169		256	55
56	CARPETING	2000	10,858	2,659	10	2,659		3,202	56
57	BORDER INSTALLATION & PAINTING	2000	23,938	5,863	10	5,863		7,060	57
58	LIGHT FIXTURES	2001	6,297	124	27.5	124		124	58
59	RUBBER ROOF	2001	7,500	148	27.5	148		148	59
60	ALARM SYSTEM	2001	34,963	689	27.5	689		689	60
61	DOOR	2001	1,975	39	27.5	39		39	61
62	LIGHT FIXTURES	2001	4,440	87	27.5	87		87	62
63	NURSE STATION	2001	6,647	131	27.5	131		131	63
64	ROOFTOP UNIT	2001	5,149	101	27.5	101		101	64
65	WATER HEATER	2001	4,853	96	27.5	96		96	65
66	SMOKE DETECTORS	2001	1,625	32	27.5	32		32	66
67	WANDERGUARDS ON MAINT DOOR	2001	3,900	77	27.5	77		77	67
68	CARPETING	2001	12,777	2,555	5	2,555		2,555	68
69	IMPROVEMENTS TO FACILITY BY PRIOR OWNER		18,872		20	944	944	16,520	69
70	TOTAL (lines 4 thru 69)		$ 3,387,216	$ 77,528		$ 134,839	$ 57,311	$ 1,730,185	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 418,147	$ 45,127	$ 41,814	$ (3,313)	10 YRS	$ 214,219	71
72	Current Year Purchases	23,507	4,701	1,175	(3,526)	10 YRS	1,175	72
73	Fully Depreciated Assets	547,879			0		547,879	73
74					0			74
75	TOTALS	$ 989,533	$ 49,828	$ 42,989	$ (6,839)		$ 763,273	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	HSKG.,DIET.,MAINT.,NSG.	93 FORD SUPREME	94	$ 39,109	$	$	$ 0	4	$ 39,109	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 39,109	$ 0	$ 0	$ 0		$ 39,109	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,448,041	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 127,356	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 177,828	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 50,472	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,532,567	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 16,809 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	SEE ATTACHED SCHEDULE		$	$ 28,052	17
18					18
19					19
20					20
21	TOTAL		$	$ 28,052	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$ 0
2	Books and Supplies				0
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 0	$ 0	$ 0
10	SUM OF line 9, col. 1 and 2 (e)	$ 0			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff			Outside Practitioner (other than consultant)		Supplies (Actual or)	Total Units	Total Cost	
			Units of Service		Cost	Units	Cost	Allocated)	(Column 2 + 4)	(Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs		$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs				93,245			93,245	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts					97,553		97,553	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	IV THERAPY MEDICARE A Other (specify): MEDICAL SUPPLIES						2,524	11,363		2,524 11,363	13
14	TOTAL				$		$ 95,769	$ 108,916		$ 204,685	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 905,353	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,473,018		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,876		6
7	Other Prepaid Expenses	4,081		7
8	Accounts Receivable (owners or related parties)	414,674		8
9	Other(specify): escrows	35,175		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,864,177	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	32,183		13
14	Buildings, at Historical Cost	2,841,389		14
15	Leasehold Improvements, at Historical Cost	492,159		15
16	Equipment, at Historical Cost	1,063,438		16
17	Accumulated Depreciation (book methods)	(2,722,510)		17
18	Deferred Charges	200,288		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	841,338		22
23	Other(specify): DEPOSIT ON FIXED ASSET	7,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,755,285	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 5,619,462	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 79,066	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	900,142		29
30	Accrued Salaries Payable	77,839		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	54,076		32
33	Accrued Interest Payable	39,018		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,150,141	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	6,512,025		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 6,512,025	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,662,166	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (2,042,704)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 5,619,462	$ 0	48

***(See instructions.)**

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,857,605)	1
2	Restatements (describe):		2
3	ROUNDING	(3)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,857,608)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(167,096)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(18,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (185,096)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (2,042,704)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,835,834	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,835,834	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	44,142	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 44,142	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 0	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,879,976	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	979,037	31
32	Health Care	2,172,456	32
33	General Administration	1,658,940	33
	B. Capital Expense		
34	Ownership	955,304	34
	C. Ancillary Expense		
35	Special Cost Centers	204,685	35
36	Provider Participation Fee	76,650	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,047,072	40
41	**Income before Income Taxes (line 30 minus line 40)****	(167,096)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (167,096)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,288	3,288	$ 70,299	$ 21.38	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,895	6,458	119,732	18.54	3
4	Licensed Practical Nurses	27,763	29,627	533,884	18.02	4
5	Nurse Aides & Orderlies	88,967	91,911	888,782	9.67	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,225	7,499	112,490	15.00	8
9	Activity Director					9
10	Activity Assistants	10,086	10,313	105,807	10.26	10
11	Social Service Workers	4,380	4,569	54,052	11.83	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	26,759	27,944	214,608	7.68	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	15,403	15,877	195,768	12.33	18
19	Laundry	14,824	15,711	102,434	6.52	19
20	Administrator	3,248	3,248	107,705	33.16	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	257	257	6,290	24.47	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,227	4,191	73,298	17.49	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	212,322	220,893	$ 2,585,149 *	$ 11.70	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 8,360	1-3	35
36	Medical Director	O	14,000	9-3	36
37	Medical Records Consultant	Number	3,871	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	900	10-3	39
40	Physical Therapy Consultant	L	8,350	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	50	11-3	44
45	Social Service Consultant	F	5,475	12-3	45
46	Other(specify) DENTAL	E	2,400		46
47	PSYCHIATRIC		135		47
48					48
49	TOTAL (lines 35 - 48)		$ 43,541		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	486	$ 21,911	10-3	50
51	Licensed Practical Nurses	470	15,946	10-3	51
52	Nurse Aides	108	2,199	10-3	52
53	TOTAL (lines 50 - 52)	1,064	$ 40,056		53

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
PAULA DEDDO	ADMIN	0	$ 44,380
KERRI HORN	ADMIN	0	37,013
BIBIANA ULRICH	ASSIST. ADMIN	0	26,312
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 107,705

B. Administrative - Other

Description	Amount
MANAGEMENT FEE	$ 332,002
TOTAL (agree to Schedule V, line 17, col. 3)	$ 332,002
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		246,755
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 246,755

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 40,934
Unemployment Compensation Insurance	35,035
FICA Taxes	195,700
Employee Health Insurance	70,276
Employee Meals	12,125
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	11,787
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	6,015
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 371,872

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	29,009
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	43,313
TRUST FEES/FRANCHISE TX/ETC	0
CONTRIBUTIONS	140
DUES & SUBSCRIPTIONS	9,503
LICENSES & PERMITS	280
TRUST FEES/FRANCHISE TX/ETC	(140)
Less: Public Relations Expense	(0)
Non-allowable advertising	(35,942)
Yellow page advertising	(7,371)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 38,792

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	7,418
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 7,418

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	6/98	$ 9,306	3 YRS	$ 1,551	$ 3,102	$ 3,102	$ 1,551	$	$	$	$	$
2	PAINT/DECORATING	6/00	7,831	3 YRS			1,305	2,610	2,610	1,306			
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 17,137		$ 1,551	$ 3,102	$ 4,407	$ 4,161	$ 2,610	$ 1,306	$	$	$

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER # 0028480 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $6705**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **76,650**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **12,125** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: MOMENCE MEADOWS NURSING CENTER #0028480 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,360	
	REPAIRS & MAINTENANCE		129	
			0	8,489
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		24,687	
	ELECTRICITY		50,255	
	WATER		14,428	
	CABLE TV - LOBBY		4,484	
			0	93,854
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		5,779	
	PAINTING & DECORATING		833	
	BUILDING REPAIRS		11,425	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		15,568	
	ELEVATOR MAINTENANCE & REPAIR		0	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		1,851	
	FIRE SERVICE		8,137	
			0	
			0	
			0	43,593
7	**OTHER**			
	SCAVENGER		10,549	
	SECURITY SERVICE		0	10,549
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	14,000	14,000

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	40,056	
	LABORATORY & XRAY EXPENSE		3,474	
	PURCHASED SERVICES		27,649	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	3,871	
	PHARMACY CONSULTANT	XVIII B 39-2	900	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	138	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		2,400	
			0	78,488
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	8,350	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	8,350
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	50	
			0	50
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	5,475	
			0	5,475
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number MOMENCE MEADOWS NURSING CENTER **#0028480** **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		158	158
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	332,002	332,002
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	5,332	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	241,423	
			0	246,755
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	35,942	
	EMPLOYEE WANT ADS	XIX F	29,009	
	CONTRIBUTIONS	VI 20 XIX F	140	
	DUES & SUBSCRIPTIONS	XIX F	9,503	
	LICENSES & PERMITS	XIX F	280	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	7,371	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	82,245
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		15,171	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		320,500	
	PENALTIES / OVERDRAFT CHARGES	VI 18	3,205	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		24	
	TELEPHONE		17,642	
	MESSENGER SERVICE		1,347	
	PERSONNEL COSTS		2,687	360,576

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	195,700	
	UNEMPLOYMENT COMPENSATION	XIX D	35,035	
	WORKERS COMPENSATION INSURANC	XIX D	40,934	
	HOSPITALIZATION INSURANCE	XIX D	70,276	
	EMPLOYEE BENEFITS - OTHER	XIX D	17,802	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	0	
	CHICAGO HEAD TAX	XIX D	0	359,747
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		5,435	5,435
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	37,092	
			0	37,092
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		18,422	18,422
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		85,264	85,264
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,790,544

MOMENCE MEADOWS NURSING CENTER
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	225,597
LESS SALES TAX	(148)
NET FOOD	225745
TOTAL PATIENT CENSUS	47,218
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	141654
ADD # EMPLOYEE MEALS/DAY	22
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	8030

PATIENT MEALS	141654
ADD EMPLOYEE MEALS	8030
TOTAL MEALS/YEAR	149684
NET FOOD	225745
DIVIDE TOTAL MEALS/YEAR	149684
COST PER MEAL	1.51
TIME EMPLOYEE MEALS	8030
EMPLOYEE MEAL RECLASSIFICATION	12125